Printed: 04/14/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	E CONSTRUCTION	(X3) DATE SU COMPLET	
		175346		B. WING		04/1	C <b>4/2015</b>
NAME OF PR	OVIDER OR SUPPLIER NOR		234 MAN	ESS, CITY, STAT NOR CIRCLE (S 66401	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL RE ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
	The following citation complaint investigation	s represent the findings on #KS00085426.	s of				
F 201 SS=D	483.12(a)(2) REASO TRANSFER/DISCHA			F 201			
	in the facility, and not resident from the faci discharge is necessa	nit each resident to rem transfer or discharge t lity unless the transfer ry for the resident's we eds cannot be met in th	he or Ifare				
	The transfer or discha						
	The safety of individuals in the facility is endangered;  The health of individuals in the facility would otherwise be endangered;						
	appropriate notice, to under Medicare or Me For a resident who be after admission to a r	ed, after reasonable and pay for (or to have pai edicaid) a stay at the factories eligible for Mechursing facility, the nurs resident only allowable aid; or	d cility. licaid ing				
	The facility ceases to	operate.					
LARGE	The facility identified with 1 reviewed for di observation, record re facility failed to ensur	not met as evidenced to a census of 35 residen scharge. Based on eview, and interview the 1 (#1) resident's disc	e harge		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		175346		B. WING		C <b>04/14/2015</b>	
	ROVIDER OR SUPPLIER		STREET ADDR		,		
ALMA MA	ANOR			NOR CIRCLI (S 66401	<b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES ST BE PRECEDED BY FULL RE ENTIFYING INFORMATION)	GULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC	ON
F 201	was necessary for the his/her needs could refind the reds could refind the reds could refind the resident was not without staff assistant seated to standing pour around while walking surface-to-surface train and wheelchair for medical to lose weight pounds (#) to approximate to a goal to lose weight pounds (#) to approximate to care for him/hersel his/her own peri-care movement, his/her own peri-care movement was able to assist state became very short of had pain.	e resident's welfare and not be met in the facility and Data Set (MDS) date revealed a Brief Interv MS) score of 15, indicatent. Verbal behavioral owards others occurred riew period. He/she waivities of daily living (AD steady but able to stab ce when moving from a osition, walking, turning, moving on/off toilet, a ansfers. He/she used a obility.  Lea Assessment (CAA) aled the resident was y due to morbid obesity from his/her current 55 imately 400#, his/her in lf such as not able to pr	ed iew ting 1 to s DLs). Silize Ind cane with 3 ability ovide ack but e end vith	F 201			

AND PLAN OF CORRECTION IDENTIFICATION	ON NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
	175346	B. WING		C <b>04/14/2015</b>
NAME OF PROVIDER OR SUPPLIER ALMA MANOR	234 M	ORESS, CITY, STAT ANOR CIRCLE , KS 66401		·
(X4) ID SUMMARY STATEMENT OF DEFI PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG OR LSC IDENTIFYING INFORM	FULL REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
wanting to hurt him/herself or others resident required staff assistance for nail care. Due to his/her weight he/sl pain and his/her legs had trouble hol up. Staff provided mobility bars on hi and both a cane and wheelchair for a care plan did not address discharge resident.  The notice of discharge letter dated by provided by the facility, revealed the notified the resident that it intended the him/her on 4/3/15 (30 days) due to a meet his/her needs related to weight noncompliance with diet recommence by the physician and dietitian, and dietitian, and dietitian, and dietitian in the presence of others. He discharged into the care of a farm. The letter included a notice to the resident right to request a hearing with information for the office of administration hearings, the state, the ombudsman advocacy and protection services for ill.  Review of the clinical record lacked documentation by the resident's phycare and services necessary that the not provide.  Observation on 4/9/15 at 3:00 P.M. resident sat on the side of the bed in room.  Interview on 4/9/15 at 3:00 P.M. with revealed he/she received a letter froon 3/4/15 explaining the facility plant discharge him/her on 4/3/15 to his/he member. The resident felt the corpor not like him due to a citation the facility had the control of the head in the resident felt the corpor not like him due to a citation the facility had the control of the head in th	bathing and he had knee ding him/her s/her bed mobility. The plans for the 8/4/15, facility o discharge in inability to ations made sruptive de/she was to ly member. Sident of in contact ative and state the mentally evidence of sician of the facility could evealed the his/her the resident in the facility need to be family ate nurse did	F 201		

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ALMA MA	ANOR			NOR CIRCLI KS 66401	Ē		
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F 201	regarding his/her roomed. He/she reported that the facility because home and he/she des resident reported the understand a low car what he/she had desidietary staff thought of he/she required a spestated he/she would be if he/she could get caunderstanding the facility needs so he/she could The resident said he/staying at the facility. was not able to take of without assistance.  Interview on 4/9/15 and administrative nursing resident told staff that facility. He/she report meetings. Staff D staff kicking him/her out of acknowledged the facility. He/she report meetings. Staff D staff discharge letter show 4/3/15. Staff D stated able to find another faceds but they were so also reported the rewas not willing to take reasons the facility has the resident was due planned diet to lose with gaining weight. Staff attempting to find him his/her needs since happy at the facility.	m on their previous sur- he/she originally came e/she was "bed ridden" sired to lose weight. The dietitian at the facility of bohydrate diet, which it ired to do. He/she felt the of him/her as a burden secial diet. The resident pe ok with leaving the face of with leaving the face of the him/her be an able in ear that could meet he dietill be near his/her face she would be okay with. The resident stated he care of him/herself at he at 2:40 P.M. with g staff D revealed the the/she desired to leave the the/she desired to leave the the facility was not	to at e lid not was ne since acility //her to nis/her amily. n //she ome  re the olan  er on not is/her the ing g the ally s meet not s not s not	F 201			

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F 201	staff A revealed the documentation from resident needed to I welfare or to have h resident had not implonger required the facility did not have physician showing or the safety of othe resident. Staff A did received a discharge due to non-payment paying 25 dollars excaught up. Staff A all not ceasing to operating the facility failed to discharge was nece	met at the facility.  at 5:08 P.M. with ng staff D and administra facility did not have a physician stating the eave the facility for his/h is/her needs met. The proved to where he/she r services of the facility. The documentation from a other people were endan rs were endangered fror report the resident had the letter previously in the the but since then had been that a month to try and ge and D reported the facility	er no he gered n the year n et was	F 201			
	A facility must provide orientation to reside and orderly transfer.  In the case of facility the administrator of written notification per to the State Survey ombudsman, reside legal representatives responsible parties,	RANSFER/DISCHRG  de sufficient preparation ints to ensure safe or discharge from the fa  closure, the individual in the facility must provide rior to the impending clo Agency the State LTC ints of the facility, and the s of the residents or othe as well as the plan for the terelocation of the residents.	cility. who is sure er	F 204			

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F 204	This Requirement is The facility identified with 1 reviewed for di observation, record refacility failed to provice orientation to 1 (#1) representation to 1 (#1) represen	not met as evidenced to a census of 35 residential ischarge. Based on eview, and interview the de sufficient preparation esident to ensure safe acharge from the facility of t	ed and and	F 204			

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F 204	The care plan dated 2 monitored the resider history of inappropriatimes behaviors that rof others around him/physician if the reside wanting to hurt him/horesident required stafnail care. Due to his/horesident required stafnail care. Due to his/horesident required stafnail care plan did not addiresident.  The notice of discharge provided by the facilit notified the resident thim/her on 4/3/15 (30 meet his/her needs renoncompliance with coby the physician and behavior in the presence discharged into the The letter included a his/her right to requesinformation for the off hearings, the state, the advocacy and protect ill.  Review of the clinical evidence of discharge involving the resident.  Observation on 4/9/11 resident sat on the signorm.	2/25/15 revealed staff of the behaviors due to a te verbal responses and any interfere with the righer. Staff notified the ent made comments of erself or others. The flassistance for bathing her weight he/she had kend trouble holding him bility bars on his/her be wheelchair for mobility. The flassistance for bathing her weight he/she had kend trouble holding him bility bars on his/her be wheelchair for mobility. The flassistance for mobility and tit intended to dischalated to weight, liet recommendations of detitian, and disruptive the care of a family members of others. He/she we care of a family members and the flassistance of administrative the ombudsman, and station services for the members of the flassistance of the members of the show the planning and preparations.	d at add	F 204			

NAME OF PROVIDER OR SUPPLIER  ALMA MANOR    C		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/O			LE CONSTRUCTION	(X3) DATE S COMPL	
ALMA MANOR  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 204  Continued From page 7 administrative nursing staff D revealed the facility did not meet with the resident to discuss discharge plans and preparation prior to or after sending the letter. Staff D reported the resident's desire to discharge to another facility or a home environment with assistance was discharge letter.  Phone interview on 4/13/15 at 3:39 P.M. with administrative staff A revealed staff did have			175346		B. WING		04	
ALMA, KS 66401  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 204  Continued From page 7 administrative nursing staff D revealed the facility did not meet with the resident to discuss desire to discharge plans and preparation prior to or after sending the letter. Staff D reported the resident's desire to discharge to another facility or a home environment with assistance was discussed in care plan meetings throughout his/her stay but nothing specific regarding the discharge letter.  Phone interview on 4/13/15 at 3:39 P.M. with administrative staff A revealed staff did have	NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE	I	
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desire to leave the facility. Staff A stated he/she gave the resident the discharge notice letter but there was no real conversation other than the facility would look for other facilities in the area that could meet his/her needs. Staff A reported the facility did not have a written out plan that was reviewed with the resident and a meeting was not held with the resident to discuss his/her discharge plans.  The facility failed to provide sufficient preparation and orientation to ensure safe and orderly discharge from the facility.	F 204	administrative nursing did not meet with the discharge plans and sending the letter. Statesire to discharge to environment with assecare plan meetings the nothing specific regard. Phone interview on 4 administrative staff A conversations with the desire to leave the fargave the resident the there was no real confacility would look for that could meet his/hot the facility did not have reviewed with the resident plans.  The facility failed to pland orientation to ensigned.	g staff D revealed the faresident to discuss preparation prior to or a aff D reported the reside another facility or a hosistance was discussed broughout his/her stay I rding the discharge letter/13/15 at 3:39 P.M. with revealed staff did have be resident about his/her cility. Staff A stated he/be discharge notice letter brown at the another facilities in the ander needs. Staff A reportive a written out plan the sident and a meeting was to discuss his/her discovered sufficient preparation or provide sufficient preparation or provide sufficient preparations are safe and orderly	after eent's ome in out eer.  th estr she eted eat was eas not charge	F 204			